

MDS 3.0 Section Q Referral FAX Transmittal Notification and Tracking Form

Nursing Facility (NF) Name:	Local Contact Agency (LCA) Name:
NF Staff Contact(s):	LCA Staff Contact(s):
NF Fax number:	LCA fax number:
NF Phone Number:	LCA Phone number:

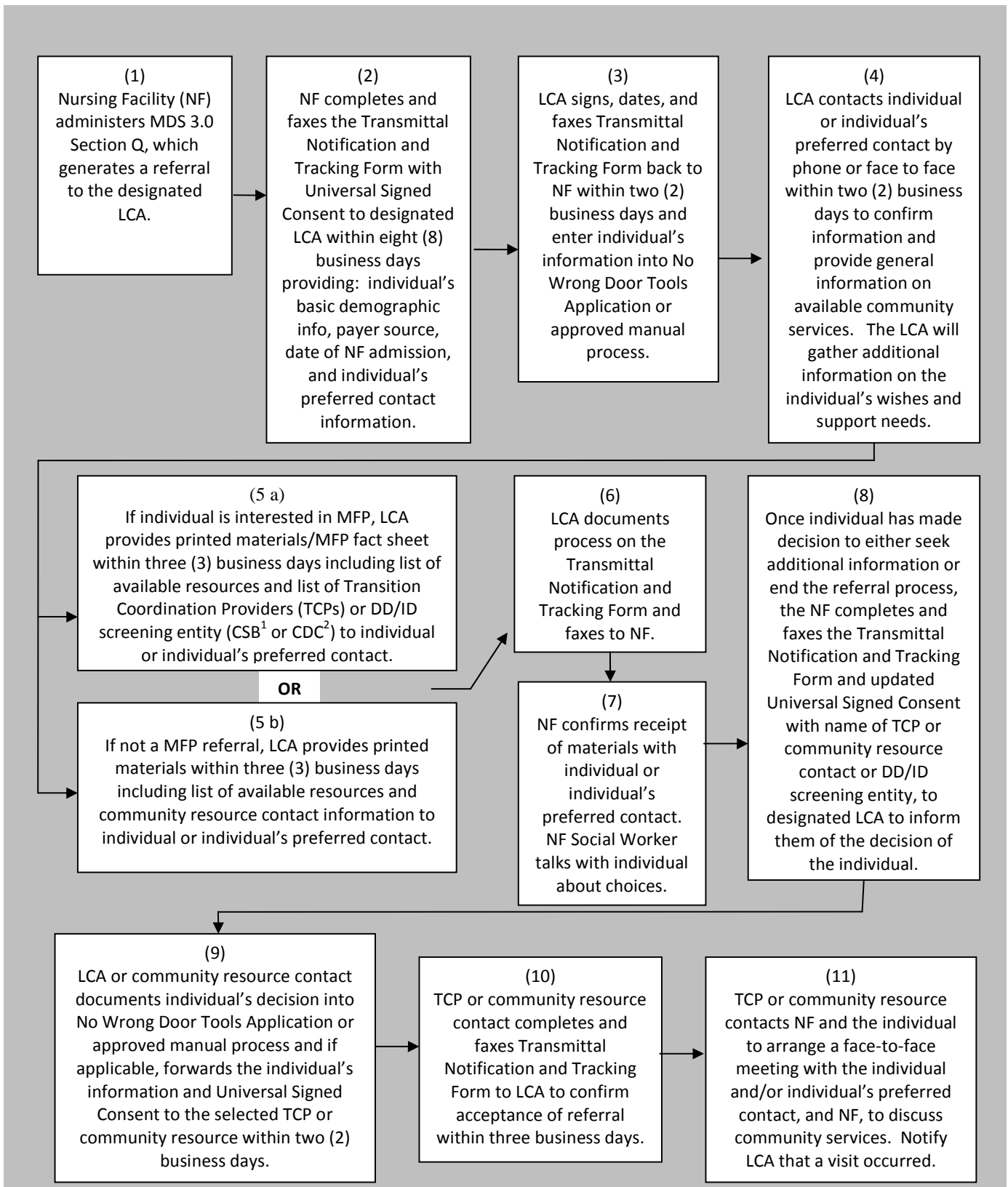
MDS 3.0 Section Q Referral Information (NF completes this section – Protocol Steps 1 and 2)

Individual's Name:	Individual's DOB:	Date of NF Admission:
Individual's Payer Source: (Check all that apply)	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Pay <input type="checkbox"/> Other	
Does the individual have any of the following:	<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Enacted Durable Power of Attorney <input type="checkbox"/> No	
Individual's Preferred Contact:	<input type="checkbox"/> Self <input type="checkbox"/> Other Relationship: _____ Name: _____	
Individual's Preferred Contact Mailing Address:	Phone Number:	Email:
Please list any communication accommodation needs the individual has:	<ul style="list-style-type: none"> • 90 consecutive days - NF admission <input type="checkbox"/> Yes <input type="checkbox"/> No • Medicaid is payer source <input type="checkbox"/> Yes <input type="checkbox"/> No • Skilled Rehab SNF level of care <input type="checkbox"/> Yes <input type="checkbox"/> No • DD (Developmental Disability) <input type="checkbox"/> Yes <input type="checkbox"/> No • ID (Intellectual Disability) <input type="checkbox"/> Yes <input type="checkbox"/> No 	

MDS 3.0 Section Q Referral Tracking

<input type="checkbox"/> Original Referral Request from NF to LCA (Step 2)	Sender:	Date:
<input type="checkbox"/> LCA Notifies NF of Receipt of Referral (Step 3)	Sender:	Date:
<input type="checkbox"/> LCA Notifies NF that LCA has Spoken with Individual and Mailed Information (Step 6)	Sender:	Date:
<input type="checkbox"/> NF Notifies LCA of Individual's Decision (Steps 7 - 8) Individual's Decision and Choice to Continue with Community Living Referral: <input type="checkbox"/> Yes, referral requested <input type="checkbox"/> No further services at this time	Sender:	Date: <input type="checkbox"/> MFP Referral <input type="checkbox"/> Transition Coordinator <input type="checkbox"/> CSB <input type="checkbox"/> DD Case Manager Name of chosen TCP: _____ <input type="checkbox"/> Community Referral Name of Community Source: _____
<input type="checkbox"/> LCA Notifies TCP/ Community Resource of Referral (Step 9)	Sender:	Date:
<input type="checkbox"/> TCP Notifies LCA of Receipt of Referral (Step 10)	Sender:	Date:

Instructions for the Completion of a MDS 3.0 Section Q Referral



Note: This referral workflow process does not negate NF discharge planning responsibilities in accordance with the Code of Virginia §32.1-138.

1. CSB – Community Services Board 2. CDC – Child Development Clinic